

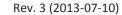
Resident Student Immunization Record

Immunization records are not confidential as required by law

NOT CONFIDENTIAL	
nization records are not confidential	

Rev. 3 (2013-07-10)

Name:		Male 🗌 Female 🔲				
Last	First	Middle				
Student ID:	Date of Birth:	mm dd yyyy				
	TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR If convenient, you may attach an official copy of your immunization records, which must include all previous/recent shots					
1. REQUIRED IMMUNIZATIONS (Laboratory	Report must be submitte	ed for any blood titers)				
MMR #1 #2 #2 Note: Measles has to be live, after 1st Birthday		Titers				
Measles #1 #2		Immune 🗌 Non-immune 🗍				
Mumps #1 #2	Date	Immune 🗌 Non-immune 🔲				
Rubella #1 #2	Date	Immune 🗌 Non-immune 🗍				
Varicella (Chicken Pox) Disease	OR	Titers				
OR Vaccine #1 #2	Date	Immune Non-immune				
Hepatitis B #1	OR	Titers				
#2 #3	Date	Immune 🗌 Non-immune 🗍				
Meningococcal Containing Vaccine: Date (Required for ALL Resident Students)						
Adult Tdap: Date						
2. TUBERCULOSIS TEST (Must be within the	6 months prior to the sta	art date of student's first semester)				
Mantoux/PPD Test						
Date Given Date Read	Result: Negativ	re Positive Sizemm (induration)				
	OR					
QuantiFERON-TB Gold or T-Spot Test						
Date Result	(M	IUST ATTACH LAB REPORT)				
If TB Test is Positive, please complete the <u>Positive TB Test Checklist</u> (Chest X-ray Required)						
Signature of Medical Provider:	Date:	License Number				
Medical Provider:		OR				
Address:		Official Stamp of				





Physical Examination

CONFIDENTIAL - TO BE COMPLETED BY A HEALTH CARE PROVIDER

Name:							-1-11-	Male
Student ID:			_	First Date of Birt	:h:		iddle d d	y y y y
MEDICAL INFORMATION	V							
Blood Pressure Height Weight Pulse							Pulse	
SYSTEMS REVIEW (If abno	rmal was chec	ked, ple	ase co	omment)				
System	Normal	Abnorn	nal	Comments				
Eyes				[Vision: Gla	asses / Co	ontacts]		
Head, Ears, Nose, Throat								
Respiratory								
Cardiovascular								
Hernia								
Genitourinary								
Musculoskeletal								
Metabolic/Endocrine								
Neuropsychiatric								
Skin								
Gynecological								
ALLERGIES / MEDICAL & PS	SYCH. CONDITI	IONS / R	ECOM	IMENDATIO	NS			
Allergic reactions to medica								
Food, insect or environmen		-						
Medical condition(s) requir								
(Include letter from M.D.)	ing ongoing ca	ie.						
Psychiatric conditions(s) red	quiring ongoing	a care.						
(Include letter from M.D.)	quiring origonit	g care.						
Physical Activity (PE, intramura	als): Unlimited	Limit	ed 🗌	[Explain:				1
Do you have any recommenda	tions regarding	the care o	of this	student? Yes	☐ No ☐]		
[If Yes, Explain:]								
Does this student have special needs that require accommodations including but not limited to academics, housing, dietary, or transportation? Yes No [If Yes, please include supporting documentation]								
Student Nurses: Any use of non-prescribed or illegal substances which may impair their ability to perform safely as a Student Nurse?								
Yes No								
Medications								
Diagnosis		Medication			Dosa	ge		Prescribing Physician
David standing Advitorations								
Psychotropic Medications		NA1' -	- 4.		D			Dona anthin - Dhanisian
Diagnosis		Medic	ation		Dosa	ge		Prescribing Physician
								<u> </u>
Signature of Medical Provi	der:				Date: _			
Modical Drovider				DI		,		OR
Medical Provider:					one: (<i>)</i>		 Official Stamp of
Address:								Medical Provider



Student Profile

CONFIDENTIAL

Information used solely to provide necessary health care

Rev. 3 (2013-07-10)

STUDENT PROFILE (To be completed	by the student in ink)		
Name:			Male
Student ID:	First Date of Birth:	Middle m m d d	уууу
Date entering FDU: m m yyy	V Citizenship:		
Admission Status: Undergraduate			
Mailing Address:			
Street A	ddress	City	State Zip Code
Home Phone: () (Leli Phone: ()	E-Mail:	
Father's/ Legal Guardian's Name:		Phone:	()
Mother's/ Legal Guardian's Name:		Phone:	()
Where do you plan to live? Resident	Commuter (If are a co	ommuter, provide the a	nddress where you will reside)
Address:		Phone:	()
Address:Street Address	City State	Zip Code	,
PERSON TO CONTACT IN CASE OF EM	ERGENCY		
Name:		Relationship:	
Address:Street A			
Street A Home Phone: () W		Cell Phone: (State Zip Code
nome Phone. () w	ork Filone. ()	Cell Filone. (<i>)</i>
HEALTH/HOSPITALIZATION INSURAN	CE		
Insurance Company Name:	Pol	icy #	Group #
Address:		Phone:	()
Street Address	City State		,
Is the student the insured? Yes No	[If No, Name of Insured:		Relationship:]
FDU Student Insurance? Yes No	FDU Student Insurance is r	equired for all Internat	ional Students.
All full-time undergraduate and gradua coverage must provide evidence of compar fees each semester. Proof of comparable waiver cards are available in	able health medical expense o	overage. Insurance pre gher Education Restruc	mium is included in the coll cturing Act of 1994. ** insuran
Permission for medical care:			
I authorize Fairleigh Dickinson University	· · · · · · · · · · · · · · · · · · ·		V
and when circumstances require immedia Permission for use of e-mail address:	ite action, to notify the emer	gency contact.	Yes No
I authorize Fairleigh Dickinson University	Student Health Services to us	e my e-mail address.	Yes No No
Student Signature:			Date:
If student is under 18 years of age:			
Parent/Guardian Signature:	Neiations		Date



Student Signature:

Medical History

CONFIDENTIAL

Rev. 3 (2013-07-10)

Name:								M	ale 🗌 Fem	nale 🗀	1
Last				First			М	iddle	uic 🗀 . c.i.		ı
Student ID:				Da ⁻	te of Birth: _	r	n m	d d y y	УУ		
FAMILY HISTORY (Check	all that a	oply.)	(Please	use COMN	ENTS sectio	n if add	ditiona	l details are ne	eded for cla	rificatio	on.)
Condition	Mother	F	ather	Sibling	Condition			Mother	Father	Sibli	ng
Alcohol/Drug abuse					High Blood	l Pressi	ure				
Asthma					Kidney Dis	ease					
Cancer					Mental/En	notiona	al Illnes	SS 🗆			
Deceased (age)					Stroke						
Heart Disease					Tuberculo	sis					
ERSONAL HEALTH HISTO	RY (Check	YES o	or NO.) (Please use	COMMENTS	sectio	n if ad	ditional details	are needed	.)	
	YES	NO				YES	NO			YES	NO
busive/controlling			Gallbla	adder troub	le			Operations or			
elationship								injury (list det	ails below)		
lcohol/drug abuse			Head i					Pneumonia			
nemia				disease/pro				Paralysis			
rthritis				itis/jaundic				Psychological	•		
sthma				lood pressu	ire			Rheumatic fev			
ronchitis			HIV/A					Self-harming b			
ancer			-	Hospitalization (list details below)				Sexually transmitted disease			
hicken Pox, if yes then ate:			Intestinal/stomach trouble					Sickle cell trait/anemia			
onvulsions/seizures			-	Kidney disease/bladder problems				Sinus trouble			
iabetes			Lyme disease				Skin disorder				
isability (Physical or earning)			-	Menstrual problems				Sleep difficulti	ies		
ar trouble/hearing loss			Migraine headaches				Smoking/toba	cco use			
ating disorder			†	nucleosis				Thyroid disease			
ye disease/vision roblems			Muscle, joint/bone disorder				Tuberculosis				
re there other aspects o	f vour heal	th the	at miaht	cause prol	olems for vo	ı or red	auire s	necial accommi	odations (in	cludina	,
cademics, housing, dieta	iry, and tro	anspo	rtation)	at FDU? If	so, please sp	ecify					
Medication/Dosage	e/Frequency	,					 Medica	tion/Dosage/Freq	uency		
RUG ALLERGIES (Please	specify.)										
<u>.LLERGIES</u> (Please specify	; include fo	ood, ir	nsect, ar	nd environm	nental allergi	es.)					
OMMENTS (If needed, p	lease conti	nue C	OMMEN	NTS section	on the back	of this	page.)				
COMMENTS (If needed, p	lease conti	nue C		NTS section							_

_____ Date: _____



Meningitis Response

IMPORTANT INFORMATION

Rev 3	(2013-07-10)
1100.3	(2013-07-10)

MENINGITIS VACCINATION INFORMATION Meningococcal meningitis is a contagious, potentially life threatening bacterial infection that causes inflammation of the membranes that surround the brain and spinal cord. Permanent brain damage, hearing loss, learning disability, limb amputation, kidney failure, or death can result from the infection. Although the disease is rare, the outbreaks of meningitis on college campuses have risen in the recent years. While the reasons are not yet fully understood, students residing in campus residence halls appear to be at a higher risk for the disease than college students overall. Vaccination is an effective way for students to protect themselves against possible infection. The vaccine provides protection against four strains of Meningococcal disease, which together account for nearly 70% of Meningococcal cases on campus. The vaccine is safe with mild and infrequent side effects. Immunity develops within seven to ten days, and remains effective for approximately five years. In the past, vaccination usually has been delayed unit an outbreak of meningitis occurs. However, because outbreaks are clustered in time, and because onset of symptoms is extremely rapid, it makes sense for students to consider reducing their risk with a vaccination before an outbreak occurs. IMPORTANT INFORMATION FOR RESIDENTS New Jersey Administrative Code 8:57-6 requires all new students who reside in campus housing to receive a meningococcal vaccination. Students who do not plan to live on campus are encouraged to consider the vaccination on a voluntary basis. Students who have received the vaccine during the five years previous to the start date of their first semester do not need to be revaccinated. Since this vaccination is mandated by law for new resident students, housing will be revoked if the vaccine is available at Fairleigh Dickinson University Student Health Services. RESPONSE (If you have received the waccine, provide verification of the same) I have already received the meningitis vaccin	Name:	Male Female				
Meningococcal meningitis is a contagious, potentially life threatening bacterial infection that causes inflammation of the membranes that surround the brain and spinal cord. Permanent brain damage, hearing loss, learning disability, limb amputation, kidney failure, or death can result from the infection. Although the disease is rare, the outbreaks of meningitis on college campuses have risen in the recent years. While the reasons are not yet fully understood, students residing in campus residence halls appear to be at a higher risk for the disease than college students overall. Vaccination is an effective way for students to protect themselves against possible infection. The vaccine provides protection against four strains of Meningococcal disease, which together account for nearly 70% of Meningococcal cases on campus. The vaccine is safe with mild and infrequent side effects. Immunity develops within seven to ten days, and remains effective for approximately five years. In the past, vaccination usually has been delayed until an outbreak of meningitis occurs. However, because outbreaks are clustered in time, and because onset of symptoms is extremely rapid, it makes sense for students to consider reducing their risk with a vaccination before an outbreak occurs. IMPORTANT INFORMATION FOR RESIDENTS New Jersey Administrative Code 8:57-6 requires all new students who reside in campus housing to receive a meningococcal vaccination. Students who do not plan to live on campus are encouraged to consider the vaccination on a voluntary basis. Students who have received the vaccine during the five years previous to the start date of their first semester do not need to be revaccinated. Since this vaccination is mandated by law for new resident students, housing will be revoked if the vaccine is not obtained prior to move-in day. VACCINE AVAILABILITY The meningitis vaccine is available at Fairleigh Dickinson University Student Health Services. RESPONSE (If you have received the meningitis vaccine within the past five						
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If student is under 18 years of age:	☐ I have decided to receive the meningitis vac	cine at some future time (Commuters Only)				
If student is under 18 years of age:	Student Signature:	Date:				
LOCULANDO DE LOCULA, REGULANDO DE LA	If student is under 18 years of age:					